in making referrals; assist the recipient in obtaining interim early intervention services when it is determined that the child has an obvious, immediate need and prepare an interim family services plan.

3. **Case management plan and coordination.** For purposes of early intervention, the case management plan will be known as the individualized family services plan (IFSP). Development of the IFSP is the translation of specific goals and objectives, and specific services, providers and timeframes to reach each objective. The case manager shall convene a meeting at a time and place convenient to the family with 45 days of the child's referral to the early intervention agency except under exceptional documented circumstances. Participants shall include: parent(s); early intervention official; case manager; the designated contact from the evaluation team; and other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

a. A statement of the child's levels of functioning in each of the following domains: physical development; cognitive development; communication development; social or emotional development; and adaptive development.

b. A physician's order pertaining to early intervention services, which includes a diagnostic statement and purpose of treatment.

c. With parental consent, a statement of the family's strengths, priorities, concerns that relate to enhancing the development of their child.

d. A statement of the major outcomes expected to be achieved and for the child and family, including timelines, and criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes and services is necessary.

e. A statement of specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity, location and the method of delivering services.

f. A statement of the natural environments in which early intervention services will be provided

g. When early intervention services are to be delivered to a recipient in a group setting without typically developing peers, the IFSP shall document the reason(s).

h. A statement of other services, including medical services, that are not required under the early intervention program but are needed by the child and the family and the payment mechanism for these services.

i. A statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated.

j. The projected dates for initiation of services and the anticipated duration of these services.

k. The name of the case manager who will be responsible for the implementation of the IFSP.

l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.

m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. **Implementation of the IFSP.** In implementing the service plan , the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. **Reassessment and IFSP update.** Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant,or if a parent requests such a review.

6. **IFSP update implementation.** The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. **Crisis intervention.** Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. **Monitoring and follow-up.** The case manager is responsible for:

a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;

b. assuring the family's satisfaction with the services provided;

c. collecting data and documenting the progress of the recipient in a case record;

d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);

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e. making alternate arrangements when services have been denied or are unavailable; and

f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. **Counseling and exit planning.** The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. **Supervisory Review/Case Conferencing.** An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation, IFSPs and other products as well as peer review or case conferencing with other case managers.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments. The case management process must be initiated by the family and the case manager through a written assessment of the child and family's need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the child's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of **CASE MANAGEMENT FUNCTIONS.**

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child's condition or circumstances.

2. Case management plan. A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under **CASE MANAGEMENT FUNCTIONS.**

3. Continuity of service. Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child's case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family's new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services for Target Group "G":

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;

2. must not duplicate certain case management services services currently provided under the Medical Assistance Program or under any other funding sources;

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "G"

1. Provider qualifications

Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

a. character and competence , including fiscal viability;

b. the capacity to provide case management services;

c. availability to provide qualified personnel as defined in subsection 2 below;

d. adherence to applicable federal and state laws and regulations;

e. the capacity and willingness to ensure case managers participate in inservice training;

f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;

g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

a. a minimum of one of the following educational or case management experience credentials:

i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or

ii. one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or

iii. one year of case management experience and an associates degree in a health or human service field; or

iv. a bachelors degree in a health and human service field.

b. demonstrated knowledge and understanding in the following areas:

i. infants and toddlers who are eligible for early intervention services;

ii. State and federal laws and regulations pertaining to the Early Intervention Program;

iii. principles of family centered services;

iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,

v. other pertinent information.

3. Individual case managers

Qualified personnel with appropriate licensure, certification or registration shall apply to the State Department of Health for approval to provide case management services. In addition, to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

a. current licensure, certification or registration in a discipline eligible to deliver services to children;

b. adherence to applicable federal and State laws and regulations;

c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;

d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;

e. completion of an approved Medicaid provider agreement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

CASE MANAGEMENT SERVICES

A. Target Group: H

See attached.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

State/Territory: New York State

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

OFFICIAL

A. TARGET GROUP H

The targeted group consists of Medical Assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program who:

(i) are seriously mentally ill; and,

(ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,

(iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

(1) heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities; or,

(2) persons with recent hospitalization in either state psychiatric centers or acute care general hospital; or,

(3) mentally ill who are homeless and live on the streets or in shelters; or,

(4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized; or,

(5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

Supportive Case Management will address the needs and desires of those persons in Target Group "H". Target Group "H" persons will be identified through the screening and intake process. The eligibility determination will be made based on individual factors in each person's life. Factors which will be considered during this process include: status of mental illness, case management options available in the community, residential situation and available options, current linkage to mental health services (including type of service, frequency and duration), linkage or lack thereof to the health care system and/or the Social Services system, the role of the criminal justice system in a person's life, as well as the individual's personal needs and goals. If

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an individual is generally not engaged in at least one of these service systems, he/she may be beter served in an Intensive Case Management program and the SCM program will make the appropriate referral and work toward linking that person into ICM. Those persons determined to be in need of Intensive Case Management but who cannot be served due to lack of capacity in ICM program will be served by SCM until the individual circumstances change or the ICM program has space available for the individual.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP H

Entire State

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "H"

Case management for Target Group "H" means those activities performed by case management staff related to ensuring that the individuals diagnosed with mental illness have full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "H" requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the person diagnosed with mental illness.

Supportive case management establishes programming directed toward a comprehensive person-centered view of recovery from mental illness. The Office of Mental Health has designed the SCM initiative to extend the personalized planning, linking, monitoring, and advocacy available through the Intensive Case Management Program target group "D" toward a wider group of persons in need. Called Supportive Case Management, this new program will be available to persons living in the community, homeless persons and persons in community support programs. The intent of the program is to provide for these individuals a comprehensive approach toward meeting their treatment, rehabilitation and support needs.

CASE MANAGEMENT FUNCTIONS

The case manager will assist the recipient in gaining access to each individual's specific area of need (ie. medical, social, education or other service). The case manager will perform needs assessments, develop a plan of care to meet the recipients's needs and interests,